COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
Public Health

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www.lapublichealth.org

Maternal Child and Adolescent Health Programs

Public Health Nurse
Perinatal Home Visitation Education Program
For first time and high risk pregnant mothers

Confidential Referral Form

Date: _____ ☐ Check here if you are the primary care perinatal provider

Person making referral: _____ Phone: (_____)_____-_____
Name and title

Provider / Agency / Facility: _____ Fax: (_____)_____-_____
☐ CPSP ☐ BIH

Name of Patient: _____ Date of Birth: _____/_____/_____

Address: _____ LMP___/___/___ EDD___/___/___
Street Apt. #

_____ Phone: (_____)_____-_____
City Zip Code

Was patient informed about this referral? ☐ Yes ☐ No Is pregnancy confidential? ☐ Yes ☐ No
Ethnicity: _____Patient's primary language: ☐ English ☐ Spanish ☐ Both ☐ Other: _____

Condition prompting referral, must meet one or more criteria below:

A. ☐ First time expectant mother less than 28 weeks pregnant (☐ Check here if client is on CalWORKs)

B. Medical:

☐ Drug / alcohol / tobacco use ☐ Teen (less than 18 y.o.) ☐ Physical disability
☐ Diabetes ☐ Entered prenatal care after 20 weeks gestation ☐ More than 35 years old
☐ Other high risk condition, describe: _____

C. Psychosocial:

☐ Family violence ☐ Depression / anxiety / mental illness
☐ No support system ☐ Inadequate money for food ☐ Unsafe living condition/homelessness
☐ History of detention within past 6 months, release date: / / PDJ # _____
Comment: _____ Booking # _____
☐ Other, describe: _____

D. Postpartum referral ☐ Mother ☐ Baby Delivery date: _____ Birth weight: _____

Describe high risk condition: _____

Fax referrals to (213) 639-1035

For first time expectant mothers less than 28 weeks call Nurse Family Partnership (NFP) @ (213) 639-6434
For all other referrals call Prenatal Care Guidance (PCG) @ (213) 639-6433

Do not write below this line, for DHS program use only.

(1) Referral received by: (Name of NFP/PCG clerk) _____Date: _____

(2) Referral faxed to: a ☐ PCG clerk ☐ NFP clerk N/A:_____ Comments:_____
b ☐ PCG PHNS ☐ NFP PHNS *in SPA #*_____☐ Date: _____

(3) Forwarded to: ☐ PCG ☐ NFP ☐ BIH ☐ Other: _____ Date: _____

(4) Sent to BIH subcontractor:_____Date: _____

Final disposition & letter completed by: Name: _____ Date: _____

☐ Enrolled (☐ PCG ☐ NFP ☐ BIH) ☐ Not enrolled Reason _____

☐ Referred to other agency: Name: _____ Date referred: _____

Contact person: _____ Agency phone: _____ Fax: _____

Comment:_____ Date:_____

☐ No HV/CM Resources Date final disposition letter faxed to referring agency: _____

Revised 12/6/03